Vermont Department of Disabilities, Aging and Independent Living

Choices for Care - Clinical Certification

The following individual has applied for Choices for Care and meets the clinical criteria.

I. Individual Information

Name: _____ Phone #: _____

SSN: _____-_____-_____ Date of Birth: _____

Mail Address*:* _____

Street Address or P.O. Box

_____

Town *State* *Zip*

Legal Representative:_____

Address: _____

Relationship to individual: _____ Phone #: _____

II. Clinical Eligibility Status & Setting

Clinical Status: ☐Highest ☐High (funding available)

Setting for LTC payment*:*☐Home ☐Enhanced Residential Care ☐Nursing Facility ☐Hospital Swing Bed

Estimated Length of Stay *(NF or Hospital SB)*: ☐ 30 days or less ☐ Over 30 days

Previous Payer Source *(NF or hospital swing bed):* Total days at previous payer source:_____
☐Private Pay ☐Medicare ☐Comm. Medicaid ☐VHAP ☐Other Ins:_____

Requested Start Date for LTC Medicaid:_____

Highest Cost Provider Nursing Home (hospital Swing bed)/ERC:___

_____

Average Cost of Services: Home-Based $3625.00/month ERC $1775. 00 /month

III. Long-Term Care Medicaid Financial Application Status

The individual: ☐Has application forms, ☐Needs application forms

IV. Choice of Case Management Agency for Home-Based and ERC setting

☐Home Health ☐Area Agency on Aging, ☐Consultant (case & counseling option ONLY)

Agency Name:_____

DAIL Long-Term Care Clinical Coordinator (LTCCC):

Name (print):_____

Signature*:* _____ ***Date***: _____

DAIL #_____

Copy to local DCF/ESD District Office, Nursing Facility and Case Management Agency

Important Information

Department for Children and Families (DCF) Economic Services Division

1. This notice serves as clinical authorization for Choices for Care.
2. Financial eligibility and patient share (if any) for Long-Term Care Medicaid must be determined.
3. The Highest Cost Provider for the home-based setting is determined on the Service Plan as developed by the case manager. LTCCC will inform DCF as soon as Service Plan is received using CFC 812 form.
4. Contact the individual or legal representative (noted on the front) for application information as needed.
5. A copy of the final DCF Medicaid Notice of Decision must be sent to the individual and/or authorized representative, highest paid provider, and the Department of Disabilities, Aging and Independent Living regional office staff (LTCCC).

Case Managers/Consultants for Choices for Care Home-Based and ERC Setting

1. This notice serves as clinical authorization as well as choice of case management agency for Choices for Care.
2. Financial eligibility and patient share (if any) for Long-Term Care Medicaid must still be determined by DCF prior to final approval for Choices for Care.
3. For Home-based setting an Independent Living Assessment and Service Plan and must be completed and submitted to the local LTCCC. *Other paperwork as required.*
4. For ERC a copy of the ERC provider's assessment, tier score worksheet and Service plan must be submitted to the local LTCCC. *Other paperwork as required.*